Verification of 180 Hours of Patient Care By Nursing Professionals

July 2005 Edition - Previous Editions Obsolete

Please print legibly

IMA's NAME/RANK _____ SSN _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE (_____) _____-_____ WORK PHONE (_____) _____-_____

IMA'S EMAIL ADDRESS_____

UNIT OF ATTACHMENT _____

I am fully qualified to be utilized by the AF in my primary/duty AFSC of _____.

IMA'S SIGNATURE _____ DATE _____

Endorsement by Civilian Employer

Name of Health Care Facility _____

Facility Address _____

City _____ State _____ Zip Code _____

Telephone (_____) _____ - _____

Employment Start Date _____ Nursing Specialty _____

I certify that the individual listed above is an employee in good standing of this organization and that said employee performs at least 180 hours of direct patient care per year.

SUPERVISOR'S NAME _____ DATE _____

SIGNATURE _____

PHONE NUMBER (_____) _____ - _____

Endorsement by HQ ARPC/SGW

Date received _____ Verifying Official _____

Nurse Corps Technician Signature
Directorate of Health Services